NAVIGATION GUIDE TO OTHER INFORMATION

A Quick Reference Guide for
SHIP Counseling

The Navigation Guides are designed for use during telephone or face-to-face counseling.

All information is presented in the second-person format, using **you** in place of he/she, the person, the beneficiary, etc.

For more detailed information or if you have questions, please contact the SHIP Training Officer at:

1-800-452-4800, extension 224.

MEDICARE for UNDER 65 and DISABLED

SECTION M

MEDICARE ELIGIBILITY
UNDER 65 AND DISABLED

You qualify for Medicare if you are under 65, disabled, and:

- You have been entitled to Social Security or Railroad Retirement Act Disability benefits for **24 months**, making you eligible for Medicare coverage in the 25th month.

- You have been diagnosed as having **End Stage Renal Disease** (**ERSD**), permanent kidney failure, need regular dialysis, or have had a kidney transplant and are receiving Social Security Disability benefits. You will be eligible for Medicare after 3 months of dialysis.

- You have been diagnosed as having **Lou Gehrig's Disease** (**ALS**), and are receiving disability benefits. You will be eligible for Medicare **immediately.**

Enrolling in Medicare

Enrollment in Medicare is automatic once you have met the eligibility requirements. Your Medicare card should arrive approximately 3 months prior to the date Medicare is scheduled to begin. You will be enrolled in both Medicare Parts A and B. You can refuse Part B by contacting your local Social Security Office.

Medicare Costs

While Medicare Part A is premium free, there is a monthly premium for Part B. Beginning in 2007 this premium will be based on your annual income. For most Medicare beneficiaries the 2010 premium will be $96.40 per month, for single beneficiaries with an annual income of $85,000 or less; married $170,000 or less. For those in these income brackets, who are new enrollees, the monthly Part B Premium will be $110.50.

In addition to the monthly premium, you will be responsible for the deductibles, co-pays, and coinsurance associated with Medicare (See *Navigation Guide 1 Medicare Parts A and B*, sections B and C.)

MEDICARE OPTIONS

Medicare Supplement Insurance (Medigap)

Medicare Supplement Insurance plans, also known as Medigap plans, are private insurance policies that are specifically designed to fill the “gaps” in Medicare. These gaps include deductibles, co-pays, and coinsurance. There are 12 standardized policies (A through L) currently approved for sale in Indiana.

Only a handful of companies offer Medigap plans to individuals who are under 65 and disabled. With few exceptions, you will not have a guarantee right to purchase a Medigap plan without medical underwriting.

You will have a guaranteed right to purchase these Medigap plans if:

- Your employer group health plan or retiree plan either ends, or your benefits are reduced significantly.
- You are enrolled in a Medicare Managed Care plan and the plan ends or no longer serves your area of residence.

When you become age 65, you will then have a 6 month enrollment period when you will have a **guarantee issue** for any Medigap plan offered in Indiana. During this time insurance companies cannot charge you a higher premium or impose a waiting period because of your disability or health history. (See Navigation Guide 2 *Medicare Supplemental Insurance*, Section F, for more information on Medigap plans).

SHIIP has a package of information that includes list of companies that offer Medigap plans to individuals under 65 and disabled. This package of information includes Centers for Medicare and Medicaid Services’ (CMS) *Choosing a Medigap Policy*.

Medicare Advantage Plans

Medicare offers beneficiaries the option to receive care through private insurance plans. These private insurance options have been known as Medicare+Choice plans, and are now called Medicare Advantage Plans.

Private insurance companies contract with CMS to manage your health care and to provide your Medicare approved services. **The most common type of Medicare Advantage plans are health maintenance organizations (HMOs), preferred provider plans (PPOs), and private-fee-for-service (PFFSs).**

You have the same rights to enroll in an Advantage Plan as those who receive Medicare due to age. There are **no waiting periods** for pre-existing conditions, and the plan must enroll you unless you have ESRD or the plan is at capacity.

To enroll, you must live in an area that is served by the Advantage Plan. There are two types of service areas, **local and regional**. Local service areas cover specific counties and/or zip codes. In order to enroll in these plans you must live in the specified area. Regional service areas offer coverage on a much larger scale, often state-wide or multi-state coverage. Indiana is in the same region as Kentucky. Any Medicare beneficiary that lives in Indiana or Kentucky, regardless of county or zip code, may enroll in a regional plan.

A list of plans is available from the SHIP website at www.medicare.in.gov; as well as, the Medicare website: www.medicare.gov.

Medicare and Employer Plans

If you have Medicare and you are covered by an employer large group health plan, (sponsored by an employer/employee organization of 100+workers), the employer plan will provide your primary coverage. Medicare will be secondary as long as the covered employee is **actively working**. Otherwise, Medicare is primary.

MEDICARE and MEDICAID

Full Medicaid Benefits

Medicaid is a joint federal and state program that helps pay your medical costs if you have a limited income and have limited assets. If you qualify for both Medicare and Medicaid, most of your medical costs will be covered. Medicaid may also pay for some services that are not covered by Medicare such as nursing home care. The income and asset limits to qualify for Medicaid are:

Full Medicaid effective April 1, 2009

	INCOME	**ASSETS**
SINGLE	$674/month	$1,500
COUPLE	$1,011/month	$2,250

For a couple with dependents, additional income of $337 per dependent may be allowed. A $15.50 monthly income disregard is not included in the figures listed above.

Medicaid Spend-Down

If you meet the assets requirement but your income is above the limits to qualify for Medicaid, you may be able to qualify for Medicaid Spend-Down. Spend-Down is a provision that allows a person, whose income is higher than the standard, to receive some assistance with medical bills under Medicaid. The Spend-Down amount is determined by the difference between the Medicaid standard (see above chart) and your monthly income. To be eligible your medical expenses must be greater than the spend-down amount.

Medicare Savings Program

If your income or assets are above the limits to qualify for full Medicaid, you may still be able to qualify for the Medicare Savings Program. This program is set up to assist qualified Medicare beneficiaries in paying their Part B Premium.

Medicare Savings figures effective January 1, 2010

		INCOME	ASSETS
QMB Qualified Medicare Beneficiary	SINGLE	$903	$6,600
	COUPLES	$1,214	$9,910
SLMB Specified Low Income Medicare Beneficiary	SINGLE	$1,083	$6,600
	COUPLES	$1,457	$9,910
QI Qualified Individual	SINGLE	$1,219	$6,600
	COUPLES	$1,640	$9,910

A $20.00 monthly income disregard is not included in the figures listed above.

If you qualify for the QMB program, you will receive assistance in paying for your Part A & Part B premiums, Medicare deductibles, and co-pays/ coinsurance. Those eligible for SLMB and QI receive assistance in paying for their monthly Part B premium,

If you believe that you may qualify for Full Medicaid, Medicaid Spend-Down and/or QMB/SLMB/QI, you will need to contact your local Department of Family Resources (formally Office of Family & Children).

COBRA

(Consolidated Omnibus Budget Reconciliation Act-1985)

COBRA is a **temporary extension** of your employer's group health coverage insurance. You must **apply within 60 days** of a specific qualifying event or you will lose your right to extend your group coverage under COBRA. The employer must notify the plan's administrator within 30 days of the qualifying event. The plan administrator must send you a COBRA election notice with in 14 days of receiving notification. To sign up, you should talk to the employer's benefits or human services division. **COBRA can help you if you are under 65 and disabled and qualify. You may find it difficult to buy other health care insurance.**

The employee and their dependent beneficiaries **must be offered the same health insurance benefits** with the same deductibles and benefit limits that they were receiving before the COBRA qualifying event.

You are eligible if:

- The employer has 20 or more employees.
- The employee has worked at least half of working days in the previous year.
- The employee is covered by the group health plan and you are in the employer group health plan on the day before the employee has a "**qualifying event**". (A specific event that causes you to lose employer group health care coverage).

Qualifying Event	Who's Eligible	Length of Eligibility
Voluntary or involuntary termination of employment/ reduction on work hours (other than for "gross misconduct)	Employee Spouse Dependent Child	18 Months
Employee enrolls in Medicare Part A or B	Spouse Dependent Child	36 Months
Employee & covered individual divorce	Spouse Dependent Child	36 Months
Employee dies	Spouse Dependent Child	36 Months
Loss of dependent child status	Dependent Child	36 Months

Under COBRA you will be paying the entire premium for coverage plus a 2% administrative charge. While this can be expensive, **compare the total cost and benefits** of COBRA coverage with the total cost and benefits of other options (including Original Medicare, Medicare Advantage Plans, Medigap policies, ICHIA, and private health care insurance) to determine what will best suit your finances and health needs. Be sure to compare:

- Prescription coverage
- Eye, dental, foot, and other coverage
- Maximum benefit limits (annual & specific types of care)
- Co-pay amounts
- Yearly deductibles

Cobra and Social Security Disability Benefits

The employer group health insurance extends for 18, 29, or 36 months, (depending on qualifying event). If you qualify for Social Security disability benefits, special rules apply to extend the 18 months of COBRA coverage to **29 months.** To receive this special coverage extension, you must notify the former employer insurance division within 60 days of receiving your disability determination.

You pay the entire premium, plus a 2% administrative charge to the continued group health plan for the first 18 months. If your disability started before your COBRA qualifying event, your group coverage could be extended to 29 months. **For the last 11 months, your premium will increase to 150% of the original premium**. If you enroll in Medicare Part A or Part B after already being on COBRA, your COBRA coverage will end.

Special Note: **If you have Medicare prior to the qualifying event, you must be offered COBRA coverage.**

For more information about COBRA, call the SHIP State Office and ask for a COBRA brochure, or call the Department of Labor for COBRA questions, 1-202-219-8784 or 1-202-219-8776. **To learn more about how to apply for Social Security or Medicare benefits, call 1-800-772-1213 (for hearing impaired, TTY: 1-800-325-0778) or visit their website at www.ssa.gov.**

ICHIA

The Indiana Comprehensive Health Insurance Association (ICHIA) is Indiana's state high risk pool plan and provides health insurance for Indiana residents who cannot obtain coverage due to health reasons. Coverage is guaranteed if you meet the eligibility requirements, but expect to pay high premiums.

ICHIA may be a good option for individuals under 65/disabled who have high drug costs, or who have been denied health insurance coverage. To be eligible for ICHIA, you must be under 65, a resident of Indiana, not eligible for Medicaid, and:

- Have been denied coverage by an insurance company;
- Had restrictions placed on coverage;
- Are unable to get an insurance plan with a premium/coverage similar to ICHIA; or
- Have been diagnosed with certain illnesses. (36 chronic, catastrophic, life-threatening diseases such as ESRD)

If you are **65 or older** and eligible for Medicare, you can not get ICHIA insurance.

ICHIA Benefits

ICHIA works through a Preferred Provider Network (PPN). If you go outside the network, benefits will usually be reduced. (Unless you are a Medicare beneficiary). Typically ICHIA will pay 80% of in network approved costs and 60% of out of network approved costs.

There are four plan options available:for 2010.

Plan Option	Deductible	Out-of-Pocket Maximum*
Plan 1	$500	$1,500
Plan 3A	$1,000	$3,000
Plan 3B	$1,500	$4,000

* including the deductible and coinsurance

After meeting a deductible which can vary from $500 to $2,500 per year, you are only responsible for coinsurance amounts. Once you reach your annual out-of-pocket maximum (deductibles plus co-insurance) the plan will pay 100% of the allowable expenses for the remainder of the calendar year.

Monthly premium rates vary with age, gender, geographic location, and chosen plan. Monthly rates can range from $112-$825. Medicare beneficiaries under age 65 and disabled do not pay higher premiums due to their disability. Preexisting conditions could be excluded for up to 3 months, if you do not have prior health insurance coverage. **Prescription Drug benefits have a separate deductible** from other ICHIA medical benefits. **Medicare beneficiaries should enroll in a Medicare Prescription Drug Plan (Part D).** By enrolling in a Part D plan, Medicare beneficiaries should see a savings in their ICHIA premium.

Dependent Eligibility

Coverage for your spouse and/or dependent children is available. Your children may be eligible for coverage if they meet one the following criteria:

- Unmarried and under 19 years of age;
- Dependent, unmarried, full time student (up to age 25); or
- Dependent Disabled Adult Child, regardless of age.

Newborns are automatically covered for the first 31 days, after that they will need to be added as an additional dependent and the monthly premium adjusted.

Medicare and ICHIA

After the ICHIA plan deductible is met, ICHIA will usually pay Medicare co-pays and deductibles at 80%. ICHIA may pay 80% of claims that Medicare denies (may pay only 60% if out of network). Individuals who are 65 or older and eligible for Medicare cannot get insurance coverage through ICHIA.

Contact **ICHIA Customer Service -1-800-552-7921**, P. O. BOX 33730, Indianapolis, IN 46203-0730. Or you can apply online at: **www.onlinehealthplan.com** Sign on as a guest, and then select Indiana Comprehensive Health Insurance Association (ICHIA).

HIP - Healthy Indiana Plan

The Healthy Indiana Plan (HIP) is for uninsured Hoosier adults between 19-64. Parents or caretaker relatives of children in the Hoosier Healthwise program are likely candidates for HIP.

Eligibility Requirements:

- You must earn **less than 200%** of the federal poverty level (FPL) for your household size.
    - A single adult earning no more than $21,660 a year, or families of four earning approximately $44,000 likely meet the basic financial requirements.
- You **cannot be eligible for Medicaid, or Medicare**.
- You **must not have access to employer health insurance** coverage - whether or not it you have chosen to use this coverage.
- You must be **uninsured for the previous 6 months**.

If you qualify for HIP, you will receive:

- A **basic health benefit package** once your annual medical costs exceed &1,100.
- A **POWER Account valued at $1,100** to pay for initial medical costs.
    - Contributions to the POWER Account are made by the State and you (based on a **sliding scale**). You will not pay more than 5% of your gross family income into the POWER Account—most pay less.
    - Any remaining funds in the POWER Account, may be rolled over to the next year providing the plan has determined you have completed all aged and gender appropriate your preventive services.
- Coverage for **preventive services up to $500 a year at no cost** to you.
    - After the $500 is met, preventative services are covered, but the POWER Account must be used if necessary.
    - Preventive services include: annual exams, smoking cessation, and mammograms.
- **Co-pays are required for all emergency services only**.
    - However, the co-pay will be returned to you if the service was deemed a true emergency.

Covered Services include:

- Physician Services
- Prescriptions - subject to a formulary (list of approved drugs)
- Diagnostic Exams
- Home Health Services
- Outpatient Hospital
- Inpatient Hospital
- Hospice
- Preventive Services
- Family Planning
- Case and Disease Management
- Mental Health Services, including substance abuse treatment

You can access the HIP application online at:

www.in.gov/fssa/hip

Applications are also available at your local Department of Family Resources and Area Agency on Aging.

You can also call **1-877-GET-HIP-9 (1-877-438-4479)** and request an application mailed to you.

Applications should be mailed to the following address:

FSSA Document Center
PO Box 1630
Marion, IN 46952

Medicare and Permanent Kidney Failure-End Stage Renal Disease (ESRD)

Medicare & ESRD

- You must require dialysis or kidney transplant.
- You can enroll in Medicare for coverage through the Social Security Administration.
- If you are able to get Medicare because of kidney failure, Medicare coverage starts the 3rd month after dialysis begins.
- Medicare coverage ends 12 months after dialysis stops.
- Medicare ends 36 months after a successful kidney transplant.

Medicare Advantage Plans and ESRD

Medicare Advantage Plans **cannot** enroll ESRD Medicare beneficiaries. If you are already in an Advantage Plan and develop ESRD, then the plan must provide coverage.

ESRD and Employer Group Health Plans (EGHP)

Employer group health plans will pay first, for a **coordination period** of 30 months, beginning the month you are eligible for Medicare. If the group plan pays all health expenses, you may want to wait until the end of the 30 -month period to enroll in Medicare. Delaying enrollment means that you will not be paying the Part B monthly premium. However, your Part B premium will be increased by 10% for each year you delay enrollment.

If you are in a group health plan and leave employment, you can continue the group health coverage by taking your COBRA option. At the end of the 30 month coordination period with COBRA and Medicare, you will

Under COBRA you will be paying the entire premium for coverage plus a 2% administrative charge. If you do not elect COBRA when you are eligible, then enrolling in Medicare could be your only option for health insurance coverage.

Medicare Part B - ESRD Coverage

Medicare will cover dialysis treatment at any approved dialysis facility including the cost of equipment, supplies, lab tests, and other services associated treatment.

Special Note:

- If you do not enroll in Medicare Part B at the time that you first become eligible, you will have to wait for the General Enrollment Period (Jan, Feb, or Mar). Medicare Part B coverage would not become effective until July.

- If you do not elect COBRA coverage, you will not have a guaranteed issue for a Medigap policy.

For further information about Medicare and ESRD:

- *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services- a supplement to your Medicare Handbook (CMS publication #CMS10128)*

- The Renal Network-to be called **only regarding quality of care complaints** in a dialysis facility, and not for information about Medicare coverage. **1-317-257-8265**

- **AdminaStar Federal**-for information about ESRD coverage. **1-800-622-4792 or online at: www.medicare.gov**